



## Initial Consultation

Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Email \_\_\_\_\_

Occupation \_\_\_\_\_

Work activity level:    Sedentary    Mildly Active    Active    Very Active

Work-related stress:    Low    Moderate    High

Regular Hours:        Yes    No

Have you suffered from or been diagnosed with any of the following:

High blood pressure	Breathing difficulties
Pulmonary disease	Vascular disease
Cancer	Recent illness
Seizures	Diabetes
Allergies	Tremors
Hernia	Back/neck pain
Joint condition/injury	Soft tissue injury
Ankle edema	Unusual fatigue
High cholesterol	High HDL cholesterol

Do you have a family history of your father or other male first-degree relative suffering an MI or sudden death before age 55?    Yes    No

Do you smoke?    Yes    No

Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by your doctor? Yes No

Do you feel pain in your chest when you do physical activity? Yes No

In the past month, have you had chest pain when you were not doing physical activity? Yes No

Do you lose your balance because of dizziness or do you ever lose consciousness? Yes No

Do you have a bone or joint problem that could be made worse by a change in your physical activity? Yes No

Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? Yes No

Do you know of any other reason why you should not do physical activity? Yes No

Have you ever exercised before? Yes No

Are you taking any medications? Yes No

Please list \_\_\_\_\_

If my health should change so that I could answer Yes to any of the above questions, I, \_\_\_\_\_, am responsible for informing my health/fitness professional

\_\_\_\_\_ Date \_\_\_\_\_

Family Physician \_\_\_\_\_

Physician's phone \_\_\_\_\_

In case of an emergency please call \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_